Similac Formula Prescription

Participant Name: _____Date of Birth: _____ Today's Date:_____

A. Formula (Required)		
Prescribed Amount: □ Maximum Allowable OR _____ per day		
Formula (select one):	**Medical Reason:**	**Length of time formula is required:**
□ Similac Sensitive (Low lactose) □ Similac Total Comfort (Partially hydrolyzed whey protein, low lactose) □ Similac for Spit Up (Rice starch added, low lactose) **No other formula may be requested with this form.**	□ Malabsorption □ Diarrhea □ Vomiting □ Reflux □ Colic □ Other: _____	□ Until first birthday (if before 9/30/14)* □ Until 9/30/14* □ Other date* _____ * These formulas may not be issued past 9/30/14

B. Supplemental Foods (for Infants 6 months and older)	
Infants (6-12 months):	**Special Instructions/Restrictions:**
□ Provide full food package □ Do not provide any foods at this time; issue formula only □ Provide a modified food package including the following foods: □ Infant cereal □ Infant vegetables/fruit	

Health Care Provider Name (Printed):_____ (Signature):_____ _Phone Number: _____

Submit to:

Local agency: _____ Phone Number: _____ Fax Number:_____